KAISER PERMANENTE
ALLIED HEALTH CARE SCHOLARSHIP PROGRAM APPLICATION

TO BE COMPLETED BY APPLICANT: **Please type or print legibly with black ink**

SECTION I – PERSONAL DATA

NAME:_____
FIRST MIDDLE LAST

MAILING
ADDRESS:_____
STREET/P.O. BOX APARTMENT NO.

_____
CITY STATE COUNTY (required) ZIP CODE

PERMANENT
ADDRESS:_____
STREET/P.O. BOX APARTMENT NO.

_____
CITY STATE COUNTY (required) ZIP CODE

HOME PHONE: ( ) _____ WORK PHONE: ( ) _____

SOCIAL SECURITY NUMBER: _____ BIRTH DATE: _____

SEX: _____ MALE _____ FEMALE ARE YOU A U.S. CITIZEN/PERMANENT RESIDENT? _____ YES _____ NO

ARE YOU A CALIFORNIA RESIDENT? _____ YES _____ NO

ARE YOU CURRENTLY UNDER A CONTRACT WITH THE FOUNDATION THAT REQUIRES A TWO-YEAR COMMITTMENT?
_____ YES _____ NO

ARE YOU A KAISER EMPLOYEE? _____ YES _____ NO

IF NO, STATE EMPLOYER'S NAME _____

PLEASE PROVIDE THE NAME OF YOUR CALIFORNIA STATE SENATOR AND CALIFORNIA STATE ASSEMBLY MEMBER.

STATE
SENATOR: _____ STATE
ASSEMBLY MEMBER: _____

CALIFORNIA DRIVER'S LICENSE/I.D. NO.: _____

ARE YOU CERTIFIED/LICENSED/REGISTERED IN ANY HEALTH CARE SPECIALTY? _____ YES _____ NO

IF SO, LICENSE NUMBER: _____ SPECIALTY: _____

PLEASE INDICATE YOUR ETHNIC BACKGROUND:

_____ African American _____ Hispanic American _____ Other (Please Specify) _____

_____ Asian American _____ Caucasian

_____ Native American (Please Specify Tribal Affiliation and "Portion") _____

PLEASE ANSWER ALL QUESTIONS IN THE SPACE PROVIDED (DO NOT ATTACH ESSAYS).

SECTION II - EDUCATION

_____ I am currently enrolled in an accredited allied health care education program in California.

_____ I have been accepted to an accredited allied health care education program for the Fall of 2000.

CHECK ONE:

_____ Laboratory _____ Pharmacist _____ Physical Therapist Assistant

_____ Medical Imaging _____ Pharmacy Technician _____ Respiratory Care

_____ Occupational Therapy _____ Physical Therapy _____ Social Work

_____ Ultrasound Technician _____Surgical Technician _____ Diagnostic Medical Sonography

_____ Other _____

NAME OF SCHOOL: _____

SCHOOL ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

SCHOOL PHONE: ( ) _____ PROGRAM DIRECTOR: _____

CLASS LEVEL: _____ (1st YEAR or 2nd YEAR)

YEAR ENTERED: _____ EXPECTED GRADUATION DATE: _____
MONTH/YEAR MONTH/YEAR

WILL YOU ATTEND SCHOOL FULL-TIME: _____ PART-TIME: _____

SECTION III – PERSONAL BACKGROUND

A. DESCRIBE YOUR WORK EXPERIENCE. TELL US ABOUT YOUR WORK AND HOW LONG YOU HAVE BEEN EMPLOYED.

B. DESCRIBE ANY COMMUNITY VOLUNTEER OR EXTRACURRICULAR ACTIVITIES YOU'VE BEEN INVOLVED IN WITHIN THE PAST TWO YEARS. FOR EXAMPLE: PRE-HEALTH CLUBS, COMMUNITY BASED ORGANIZATIONS, OTHER STUDENT ORGANIZATIONS, COMMUNITY CENTERS, CIVIC COMMITTEES, POLITICAL WORK, PROFESSIONAL ASSOCIATIONS OR CHURCHES. DESCRIBE ANY SERVICE OR ACTIVITIES YOU'VE DONE IN UNDERSERVED AREAS **(Attach letters verifying your community service within the past two years).**

C. DESCRIBE YOUR CAREER GOALS.

What kind of work would you like to do immediately after graduation?

What kind of work do you think you'll be doing in five years?

Try to tell the committee your vision of your professional future.

D. BACKGROUND. FOR EXAMPLE: WHERE DID YOU GROW UP (CITY, STATE)? WHAT WAS YOUR NEIGHBORHOOD LIKE? HOW IS YOUR BACKGROUND RELEVANT TO YOUR INTEREST IN PURSUING AN ALLIED HEALTH CARE CAREER?

SECTION IV – FINANCIAL NEED

Check the term(s) of the 2000/2001 academic year for which you will be enrolled and are requesting scholarship assistance:

☐ Fall Semester/Ouarter ☐ Winter Quarter ☐ Spring Semester/Quarter ☐ Other (list) _____

Enter the total amount of the scholarship you are requesting (the maximum amount is **$1,000** or **$1,500** per academic year *see application guidelines*) _____

Have you applied/do you plan to apply for financial aid from the college you will attend? ☐ Yes ☐ No

If not, please indicate why _____

How much do you expect your education to cost this academic year: _____

Identify other scholarships, loans and financial aid you expect to receive in the area below.

In the following section, list expenses and resources that correspond to the period you expect to enroll for the 2000/2001 academic year.

Please Outline Your School Budget:	Educational Expenses	Annual Resources	Financial Need
1. Tuition and mandatory fees	$_____	$_____	$_____
2. Books and supplies	$_____	$_____	$_____
3. Living Expenses	$_____	$_____	$_____
4. Family Obligation	$_____	$_____	$_____
5. Other (explain)	$_____	$_____	$_____
Total	$_____	$_____	$_____

GRADUATION DATE VERIFICATION FORM
MUST BE COMPLETED BY THE PROGRAM DIRECTOR

THE KAISER PERMANENTE ALLIED HEALTH CARE SCHOLARSHIP PROGRAM

Applicant's Name: _____

School of Allied Health: _____

Address: _____

Year Entered: _____ Expected Graduation Date: _____
Month/Year Month/Year

Additional Comments Regarding the Allied Health Student

Name (Please Print) _____ **Title** _____

Signature _____ **Date** _____

Phone Number ( )_____

CHECK LIST: DID YOU INCLUDE?

_____ ALL SECTIONS (Pages 1-7) OF THE APPLICATION

_____ GRADUATION DATE VERIFICATION FORM – **COMPLETED BY PROGRAM DIRECTOR**

_____ **OFFICIAL** COLLEGE TRANSCRIPTS (AS STATED IN THE "CRITERIA FOR SELECTION" SECTION OF THE APPLICATION)

_____ 3 ORIGINAL LETTERS OF RECOMMENDATION ON LETTERHEAD (AS STATED IN THE "ELIGIBILITY" SECTION OF THE APPLICATION)

_____ DOCUMENTATION OF COMMUNITY SERVICE WITHIN THE PAST TWO YEARS

_____ FINANCIAL AID DOCUMENTATION (IF NOT AVAILABLE, SUBMIT A COPY OF 1999 TAX RETURN ALONG WITH W-2s AND/OR 1099s)

NOTE: IT IS THE RESPONSIBILITY OF THE APPLICANT TO CONTACT THE FOUNDATION OFFICE AT (800) 773-1669 TO VERIFY WHETHER THEIR APPLICATION WAS RECEIVED COMPLETE AND ACCURATE. THE FOUNDATION WILL NOT PLACE CALLS TO REQUEST ADDITIONAL INFORMATION OR CLARIFY ANY INFORMATION PROVIDED.

AND

PLEASE REMEMBER TO DUPLICATE APPLICATIONS PRIOR TO SUBMISSION. THE FOUNDATION WILL NOT RETURN ANY ORIGINALS OR COPIES OF THE APPLICATION PACKET.

I certify that all statements in this application are complete and accurate. I also authorize the Foundation to verify any information included on the application form and/or the attachments submitted with the application. I understand that falsification will disqualify my application and the appropriate licensing board will be notified.

Signature: _____ Date: _____

INCOMPLETE APPLICATION PACKETS WILL NOT BE EVALUATED

RETURN APPLICATION TO:
HEALTH PROFESSIONS EDUCATION FOUNDATION
1600 9th Street, Suite 436
Sacramento, CA 95814

FOR OFFICE USE ONLY

COMPLETE: YES _____ NO _____ IF NO, STATE REASON _____

RECEIVED BY: _____ (initials)